February 25, 2011

The Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization that has represented health-related issues of federally-recognized Tribes in Washington, Oregon, and Idaho for the last thirty-seven years. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts legislative and budget analysis, interprets regulations and policy issues related to health care, conducts health research, and offers health promotion projects.

Federal Responsibility for Health Care to American Indian/Alaska Native People

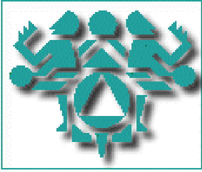
Many of our Northwest Tribes are among those who signed treaties with the United States that established the Federal responsibility to provide health care for Indian people. The Federal government has a unique legal and moral obligation to provide health care to Indian people--an obligation paid for with millions of acres of land and billions of dollars of resources. This obligation has been affirmed many times through treaties and executive orders, legislation, and by policy declarations of Presidential Administrations and Congress.

Northwest Tribes continue to exercise more control over their health care programs in all tribal communities, whether using contracting and compacting options provided by the Indian Self-Determination and Education Assistance Act (P.L. 93-638) or through IHS direct service. Tribes ensure that Federal funds reach the community level where they will be used to maximize care for patients. The diversity of the programs in the Northwest reflects this Nation's policy of tribal self-determination.

Indian Health Programs have achieved success despite chronic under-funding

Over 104,000 Indian people in Oregon, Washington, and Idaho receive their primary health care from Indian health programs. Nationally, over 2.1 million American Indian/Alaska Natives receive care from Indian health programs. In many areas of the county, the Indian health care provider is their only option for health care. The partnerships forged among Congress, Tribal Governments, urban Indian health organizations, and the Indian Health Service over the last 60 years has resulted in significant improvements in the health status of Indian people. While American Indians continue to lag behind in a number of health status measurements, real progress has been achieved. Death rates of Indian people from infectious diseases, gastrointestinal diseases, and tuberculosis have decreased dramatically. In the Northwest, mortality from sudden infant death syndrome has declined significantly and other diseases have been prevented due to the increased emphasis on health promotion and disease prevention projects for diabetes, HIV/AIDS, cancer, and commercial tobacco use.

As the federal government moves to tie funding to performance, the nation's Indian Health Programs should stand out as worthy of increases. Indian health programs are models of what the Federal government can accomplish at its best.



Northwest Portland Area Indian Health Board

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2012 Legislative Plan

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization that represents health care issues of 43 federally-recognized Tribes in WA, OR, and ID. The following is a summary of legislative priorities for the 112th Congress and policy recommendations for the Administration. A detailed analysis of these issues is presented in our full *2011 Legislative Plan* available at www.npaiihb.org.

Health Reform Implementation

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. One week later, he also signed the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act, the act, or federal health reform.

In response to federal health reform, federal agencies and states legislatures have begun setting up infrastructure for implementing the new law. State implementation efforts continue to build as provisions take effect and timelines are developed. To date, some of the most common efforts include creating task forces or appointing officials responsible for moving forward with federal requirements and closely examining how to implement major provisions such as health insurance exchanges and subsidies, insurance market reforms, high risk pools and Medicaid expansion. These efforts also include funding available for states to assist in implementation efforts.

All of the implementation efforts by state and federal government will impact the delivery of heal that care for American Indian and Alaska Native (AI/AN) people. There are Indian specific provisions intended to protect AI/AN participation in the new health reform programs that will be created by states and the federal government.

Individual Mandate: (Title I, Section 1501(b)). The ACA makes most Americans responsible to carry some form of health insurance coverage. Compliance with this requirement will be enforced through the use of tax penalties by the Internal Revenue Service. The law exempts members of Indian Tribes on the basis of the federal trust relationship.

Payer of Last Resort: (Title II, Section 2901(c)). The new law makes health programs operated by IHS, tribes/tribal organizations and urban Indian organizations (I/T/Us) the payer of last resort for persons eligible for services through those programs. This key provision removes any doubt that other health coverage - e.g., Medicare, Medicaid, or private insurance - carried by an IHS eligible person is required to pay before IHS or a Tribe is is required to pay.

Insurance Exchange: (Title II, Section 1402). Individuals who do not have health coverage through their employer would be able to purchase coverage through state-based insurance exchanges by 2014. Three Indian specific provisions will protect Indians from cost sharing requirements at or below 300% of FPL, a second protects Indians from any cost sharing for service delivered through an IHS program, and Indians will be allowed to enroll in Exchange plans on a monthly basis.

Tribes as Express Lane Agencies: (Title II, Section 2901(c)). Effective March 23, 3010, the new law adds the Indian Health Service, Indian tribes, tribal organizations and urban Indian organizations to the list of public agencies who have "express lane agency" status for purposes of making eligibility determinations for Medicaid and CHIP.

Medicare Part B: (Title II, Section 2902). Removes the sunset date of December 31, 2009, to allow IHS and Tribal programs permanent authority to receive reimbursement for Part B services. Provision initially passed in Medicare Modernization Act of 2003 limited authority to a five-year period.

Medicare Part D "TrOOP fix: (Title III, Section 3314). Effective January 1, 2011, the value of drugs provided by IHS programs will now count toward "true out of pocket" costs.

Tax Exemption on Tribal Health Benefits: (Title IX, Section 9021). Effective March 23, 2010, the law excludes from an individual Tribal member's gross income the value of health benefits, care, or coverage provided by IHS programs, a Tribe, or tribal organization.

RECOMMENDATION:
Federal and state agencies responsible for implementing the ACA must include Tribes and should work with NPAIHB and other tribal health organizations to implement these Indian specific provisions.

The federal budget reductions currently being discussed by the Administration and recently passed in H.R. 1 are very draconian and hold the likelihood to have lasting effects on the Indian health system. Because of the chronic underfunding of the Indian health system and the severe health disparities of Indian people it is essential to preserve and fund IHS and Tribal health programs.

The past year's IHS budgets have assumed a heavy burden of recent neglect. The IHS budget from FY 2002 to FY 2007 saw less than 2.5% increases for health service accounts. A growing population and medical inflation eroded the purchasing power of Indian health programs. Tribes were forced to redirect funding from economic development initiatives to supplement their health programs. Fortunately, expanding Medicaid and Children's Health Insurance programs provided additional resources. There is no denying, however, that a huge and growing gap resulted in greater health care disparities between Indian people and the general population over the past ten years.

RECOMMENDATION: Because of the chronic and severe underfunding of the Indian health system—along with the significant health disparities of Indian people—the IHS should be exempt from any discretionary funding budget reduction targets.

FY 2011 IHS Budget & Mandatory Costs

The President's FY 2011 budget included $4.4 billion for the Indian Health Service (IHS). This marks the second year of remarkable support by the Obama Administration to fund Indian health programs. Last year's enacted FY 2010 budget included a $471.3 million increase (13.2%) increase for the IHS that began with a generous President's request. The recent action taken in H.R. 1 will significantly reduce the level of funding for IHS programs. The House bill reduces the level of funding that the President requested by $267 million. The increase provided for IHS in H.R. 1 is a mere $87 million and less than what is required to maintain current services, fund inflation and population growth, and will result in cutting health services for Indian people.

In FY 2011, NPAIHB estimated that it would take $465.4 million to maintain current service requirements. NPAIHB strongly urges Congress to provide the necessary funding to maintain current services and not erode the funding base of Indian health programs.

Full Funding for Contract Support Costs

P.L. 93-638 authorizes Tribes to manage programs previously administered by federal agencies. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and strengthened Tribal governments and institutions for Indian people. The IHS estimates a shortfall of approximately $146.1 million in contract support costs. NPAIHB recommends a $146.1 million increase in the appropriation for contract support costs.

Permanent Funding for Epidemiology Centers

Tribal Epidemiology Center programs were authorized by Congress as a way to provide significant support to multiple Tribes in each of the IHS Areas. The President's only requests an increase of $208,000 to cover the increased expense of operating twelve Epidemiology Centers. The twelve Epidemiology Centers provide critical support for tribal efforts in managing local health programs. The Northwest Portland Area Indian Health Board supports permanent funding for Tribal Epidemiology Centers.

Increase Funding for Substance Abuse in the Mental Health and Alcohol Line Items

The President's budget proposes a slight increase of $11.3 million for alcohol and substance abuse funding programs. More needs to be done to address the behavioral health needs of tribal communities. The circle of violence, depression, and substance abuse continues to plague tribal communities. Methamphetamine use is on the rise resulting in tremendous costs to the Indian health care system. Currently, there are no Tribal programs in the Northwest that provide for this type of treatment for adults. NPAIHB recommends an additional $100,000 for the IHS alcohol substance abuse line item if we are to make a difference.

Health Facilities Construction Funding

Although the IHS is working to improve the Health Facilities Construction Priority System (HFCPS), there are many tribal health facilities that will never be replaced or renovated under the current HFCPS. The Joint Venture (JV) and Small Ambulatory (SAP) Programs are an efficient way to maximize resources of the federal government. The current priority list was developed in 1991 and virtually locks out Tribes from much needed construction dollars unless they are one of the facilities on the current list. If facilities construction funding is restored, it is recommended that the JV and SAP programs each receive $10 million in FY 2011.

Legislative Priorities

Permanent Reauthorization of the SDPI

Congress established the Special Diabetes Program for Indians (SDPI) in the Balanced Budget Act of 1997 to provide for the prevention and treatment services to address the growing problem of diabetes in Indian Country. Congress recently extended the Act through FY 2013 however should permanently extend the Act. The SDPI provides a comprehensive source of funding to address diabetes issues in Tribal communities that successfully provide diabetes prevention and treatment services for AI/ANs and have resulted in short-term, intermediate, and long-term positive outcomes.

Medicare and Medicaid Programs

The most significant trend affecting Indian programs are declining Medicaid reimbursements attributed to state fiscal crisis. As states curtail Medicaid services to balance budgets it impacts third party collections for Tribal health programs despite the fact that states are reimbursed at 100% FMAP for services provided at IHS and Tribal facilities. This could be addressed with special waivers based on the unique legal and political status of Indian people. In at least one instance, CMS has informed at least one state that they could provide additional benefits delivered through the Indian health system.

NPAIHB commends CMS for this policy decision and it is one that acknowledges the federal government's unique legal responsibilities under the trust obligation to provide recognized privileges to American Indians and Alaska Natives. In recognition of the trust obligation, the Indian Health Care Improvement Act of 1976 states:

> *"federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."*

This standard holds that the federal government's unique legal responsibilities under the trust obligation permits AI/ANs to be treated differently in federal programs because of the political status of Tribes as sovereign nations and is the standard that should be followed by CMS in determining eligibility, access to services and cost sharing issues. NPAIHB recommends that CMS provide the technical assistance to states requesting similar action in order to develop waiver programs to accomplish the policy objective of exempting AI/ANs from Medicaid benefit reductions.

Title VI Self-Governance Legislation

When Congress enacted the Self-Governance legislation, it included a provision requiring the HHS to carry out a study of the feasibility of assuming responsibility for non-IHS programs. A Title VI Self-Governance feasibility study found that such a demonstration is feasible for eleven programs. The HHS Secretary should encourage the Administration and Congress to move to enact a non-IHS self-governance demonstration project. HHS should also work with Tribes to design a Self-Governance demonstration for the 11 programs identified in the feasibility study.

Support transfer of IHS Appropriations from jurisdiction of Interior, Environment & Related Appropriations to Labor, Health and Human Services, Education and Related Appropriations.

Both, the National Congress of American Indians (NCAI) and the Affiliated Tribes of Northwest Indians (ATNI) support moving the IHS budget from the Interior Appropriations Sub-Committee to the Labor, Health and Human Services, and Education (LHE) Appropriations Sub-Committee. The LHE Committee handles health care related bills, and therefore understands the problems associated with health care delivery, such as medical inflationary rates. The Interior Appropriations Subcommittee is responsible for national parks, reclamation projects, mining activities, fish and wildlife, and other natural resource programs. It is reasoned that the IHS appropriation would benefit by being in the same pool of health expenditures that programs like Medicare, Medicaid, SCHIP, and other health programs appropriated out of the LHE Appropriations Subcommittee. The Labor-HHS-Education subcommittees have almost always been allocated appropriation increases that match or exceed health inflation indexes. While the Interior Appropriation Subcommittee allocations reflect natural resource program inflation rates, which generally fall below health inflation.

Other Health Priorities

Special Appropriation for Northwest Regional Youth Treatment Program

Regional Youth Treatment Centers provide drug and alcohol treatment for adolescents of federally recognized Tribes. AI/AN youth are at higher risk and suffer the effects of alcohol and substance abuse at a higher rate than other non-Indian youth. The Klamath Tribe operates the only dual diagnosis [mental health and drug and alcohol addiction] facility for Indian youth in the United States. The program is located in a 6,500 square foot house that is over 35 years old and in considerable need of repair. It is less than adequate to house youth and for providing services. The tribe has purchased six acres of land for a future building however does not have the capital to build a new facility. NPAIHB requests Congress make a special appropriation of $5 million

to the Klamath Tribe for construction of a new facility for the Klamath Alcohol and Drug Abuse program.

Long Term Care (LTC) and Elder Issues

The IHS does not fund long-term care, which is why there are few long-term care services in Indian communities. There are only 15 known tribal nursing homes in the nation. NPAHB supports the study of the long-term care needs of AI/AN people. Tribes need more case management funding and funding to allow Tribes to provide advice on long-term care needs to their elders. Medicare and Medicaid programs could become important sources of funding for long term and home and community based care for elders with support from CMS. The IHS should receive a line-item appropriation to study long-term care programs in Tribal communities. Elder issues and Long Term Care (LTC) are a growing concern for Tribes across the country.

Veterans Health Issues

Indian Country has long recognized the growing concerns and frustrations of AI/AN veterans in obtaining health services from the IHS and Veterans Administration (VA). Often there are redundancies in treatment when veterans obtain health services at an IHS or VA facility. AI/AN veterans have advocated that the VA and IHS accept one another's diagnoses without the requirement of additional diagnoses for referrals. These conditions cause an undue burden on veterans when seeking services and are causing unnecessary costs to both the IHS and VA. This stress often serves as a barrier to seeking health care and illness goes untreated. Congress should direct the IHS and VA to identify needs and gaps in services and develop and implement strategies to provide care to AI/AN Veterans. The agencies should work to develop strategies for information sharing of patient records and data exchange so patients do not have to undergo a duplication of service for referrals.

Regional Referral Specialty Care Centers

Portland Area Tribes have been very innovative in developing alternatives for facilities construction. The Portland Area Tribes have recently completed a Pilot Study to evaluate the feasibility of regional referral centers in the IHS system. This effort is consistent with the IHS Directors initiative to bring reform to the IHS. The Pilot Study concludes that the demand for a Regional Specialty Referral Centers, when strategically placed, to offer specialty care, diagnostics, and ambulatory surgery care are economically feasible and should be further explored and funded. This effort demonstrates the viability of Regional Specialty Referral Centers using a "market erosion" methodology that factored user-population data of participating Tribes, reasonable travel distances, health care competitors (providers), and economics of payer groups to derive utilization rates for a regional specialty referral center. The Study further recommends that a demonstration project be completed in the IHS.

Recommendation: Request the appropriations committees include $3.4 million for planning and design of regional referral specialty care center demonstration project in the Portland Area.

Implementation of IHCIA Priorities

The reauthorization of the IHCIA makes improvements to or adds new provisions that will improve the Indian health care system in several ways. The legislation sets to improve workforce development and recruitment of health professionals, it also provides new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs, and creates opportunities to improve access and financing of health care services for American Indian and Alaska Natives.

For example, the law now allows IHS to carry out long term-care related services and be reimbursed for them, such as home and community based services. The bill makes a marked improvement at modernizing the delivery of health services provided by IHS, but this can only happen if the new provisions are implemented in a timely and effective manner. IHS should not have unilateral authority to interpret specific provisions in the law or to drive key policy decisions that will have a direct impact on Tribal governments and the members they serve.

While IHS plays a vital role within the federal agencies' internal discussions, their role is limited to the very specific authorities they are granted and further bound by the constraints of their current system and personnel. Northwest Tribes have always been strong partners with IHS within the context of their mission; however, both ACA and IHCIA go far beyond the current capacity of IHS policy and regulatory expertise.

In those areas, IHS should not be tasked, alone, with representing Tribal interests. In fact, there have been times when IHS has been unable to appreciate the importance of Tribal innovations to provide more appropriate and effective health services to their American Indian and Alaska Native beneficiaries. In order for ACA and IHCIA to have a positive impact in Tribal communities, the Administration must involve Tribes in implementation discussions immediately.
The following outline IHCIA provisions that Northwest Tribes have expressed concern about the IHS moving forward with implementation (this list is not comprehensive of all Tribal concerns and is not provided in priority order):

Sec. 157. Access to Federal Insurance (Sec. 409): The main challenge here is that IHS has failed to include Tribes in preliminary discussions with OPM. These types are meetings

are critical in defining who will be eligible federal insurance, establishing administrative mechanisms (billing, payment, etc.). Tribal consultation has also been conducted with little information provided to Tribes. IHS has no organizational interest in this provision except to the extent that this new option would provide savings to Tribes which could then be reprogrammed back into health care services. The provision does not have an impact on the federal or IHS budget. IHS does not understand how many Tribes currently are structured beyond health services nor how they provide employee benefits. Little specific information has even been shared with Tribes on process or progress. Tribes are becoming increasingly concerned about the possibility that IHS may attempt to limit this benefit in ways the law was not intended.

Sec. 154. Sharing Arrangements with Federal Agencies (Sec. 405): IHS has indicated that preliminary meetings have occurred with the DOD/VA. There does not seem to be any progress by IHS in setting up eligibility or billing mechanisms. Early indications by IHS reveal that there are legal interpretation issues by DOD/VA about eligibility and application of the legislation. Implementing this provision successfully will require a coordinated effort among all of the federal agencies as well as the Centers for Medicare & Medicaid services (CMS). There will be tri-eligibles resulting from this new authority (Medicare/Medicaid, IHS, and DoD/VA eligible). This is just one example of the complex legal and policy negotiations that must take place to implement the law and Tribal involvement will be critical to address these issues.

Sec. 113. Exemption From Payment of Certain Fees (Sec. 124): This provision extends the exemption from Federal agency licensing fees available to the Public Health Service Commission Corps to employees of tribal health programs and urban Indian organizations. IHS has been reluctant to confirm if this exemption applies only to individuals or if this mean a facility is exempt. Tribes feel that it should the facility, consistent with the treatment of IHS direct operated programs.

Sec. 130. Epidemiology Centers (Sec. 214): This provision confers epidemiology centers the status of public health authorities for purposes of the Health Insurance Portability and Accountability Act of 1996. The National EpiCenter Office has indicated that making the Tribal EpiCenters (TEC) Pubic Health Authorities does not mean that IHS/HHS "must" give them Protected Health Information (access to health data to carry out important EpiCenter functions) and that the language is intended as "permissive" and not “mandatory". The intent of Congress was to allow TECs access to important to carry out their functions. There seems to be reluctance by IHS’ National EpiCenter program to recognize this new authority. While this list is not exhaustive of all concerns that Tribes may have encountered with IHS in implementing the new law, it does represent that fact that implementation issues are complex and would best be accomplished with input from Tribal health program and policy experts.

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